PHYSICIAN'S EXAM

SECTIONS 7, 8 AND 9 (PAGES 5 & 6) MUST BE FILLED OUT BY A DOCTOR

SECTION 7: STANDING INDIVIDUALIZED ORDERS FOR: Camper's Name: _____

Prescription Medications: Please complete with patient's current regimen for both scheduled and PRN medications:

Drug Name	Route	Dosage	Schedule and Indications	Comments

Standard Over the Counter/PRN Medications: (The following medications are available in the health cabin and will be administered at the discretion of the Camp Nurse, if approval is indicated by the camper's healthcare provider).
No response on this section will assume the answer is no.

Drug Name	Dosage	Schedule and Indications	Healthcare Provider Order	Comments
Tylenol	Per label instructions by age/weight	Q 4 hr as needed for pain or fever > 100°F	❑Yes ❑No	
Ibuprofen	Per label instructions by age/weight	Q 6 hr as needed for pain or fever > 100° F	❑Yes ❑No	
Robitussin	Per label instructions by age/weight	Q 4 hr as needed for cough	❑Yes ❑No	
Pepto-Bismol	Per label instructions by age/weight	Q 30 min to 1 hr as needed for diarrhea (no>8 doses/24 hr)	❑Yes ❑No	
Mylanta	Per label instructions by age/weight	BID-TID as needed for stomach upset	❑Yes ❑No	
Dimetapp	Per label instructions by age/weight	Q 6-8 hr as needed for nasal congestion/drainage	❑Yes ❑No	
Benadryl	Per label instructions by age/weight	Q 6 hr as needed for allergic reaction (hives, insect bite)	❑Yes ❑No	
Calamine Lotion	Per label instructions	As needed for itching, bug bites and stings	❑Yes ❑No	
Bacitracin Ointment	Per label instructions	As needed for superficial wounds	❑Yes ❑No	
Hydrocortisome	Per label instructions	As needed for superficial swelling	❑Yes ❑No	

SECTION 8: HEALTH CARE RECOMMENDATIONS BY LICENSED FAMILY PHYSICIAN

DOB _____ Weight _____ Height _____ BP _____

In my opinion, the above camper/staff: ❑ is ❑ is not able to participate in an active camp program.

The camper/staff is under the care of a physician for the following conditions: _____

_____

_____

Any medically-prescribed meal plan or dietary restrictions: _____

_____

Known allergies to medication, food or other (insect stings, tree nuts, asthma, animals, etc.): _____

_____

_____

Description of any limitation or restriction on camp activities: _____

_____

_____

Date of last tetanus shot:_____ Are immunizations up to date? ❑ Yes ❑ No

The following section must be signed or stamped by a Health Care Provider. Without this authorization your camper cannot be accepted into Camp Scully.

SECTION 9: HEALTH CARE PROVIDER AUTHORIZATIONS

Note: Parent/Guardian must also sign this box

Camper's Health Care Provider Name: _____

Address: _____ Phone: _____

Signature: _____ License #: _____

Date: _____

I have read the doctor's documentation in Sections 7 and 8 and I agree with the physician's individual medical orders for my child.

Signature of Parent/Guardian _____ Date _____